OAK MILL
Medical Associates

Patient Registration Form

First Name:_____ **MI**:_____ **Last Name**:_____

Mailing Address:_____

City: _____ **State**:_____ **Zip Code**: _____

Home Number: (_____) _____-_____ _____OK to leave message with detailed information _____ Leave message with call back numbers only **Cell Phone**: (_____) _____-_____ _____OK to leave message with detailed information _____ Leave message with call back numbers only **Pharmacy:** (_____) _____-_____	**Work Number:** (_____) _____-_____ _____OK to leave message with detailed information _____ Leave message with call back numbers only **E-mail through Pt Portal: _____** _____OK to send health information to portal _____ NOT ok to send health information to portal **Mail Order Pharmacy:** (_____) _____-_____

Date of Birth: ____/____/_____ Social **Security #:** ____-____-_____ Gender **(Circle one):** Male or Female

Race: _____ Ethnicity: _____ Preferred **1st Language:** _____

Marital Status (Circle One): Single/Married/Widowed **Employed (Circle One):** None/Retired/ Full-time/Part-time

Name of Employer: _____ **City**: _____ **State**: _____

Emergency Contact Name: _____ **Phone #:** _____**Relationship**: _____

To enroll in electronic statements and paying online please check area below and enter the last 4 digits of you SS#
I opt in for electronic statements/payments: _____
Last 4 digits of SS#: _____

Primary Insurance: Insured Employer Name: _____ Insurance Plan Name: _____ ID #: _____ Group #: _____	**Secondary Insurance:** Insured Employer Name: _____ Insurance Plan Name: _____ ID #: _____ Group #: _____

Are you the sponsor of the above Insurance? Y/N
IF NOT, please provide the following:
Spouse/Parent Name: _____
Date of Birth: _____/_____/_____
Social Security #: _____-_____-_____

*Co-pays and balances are due at the time of service. We will bill only two contracted insurance companies; however, you are ultimately responsible for all charges whether the insurance company paid for claim or not. We accept checks, cash, and most credit cards, I hereby authorize OMMA and staff to disclose my individually identifiable health information to the insurance carrier(s) OMMA will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to e-disclosure by the recipient and may no longer be protected by federal or state law.

Patient, Guardian, and/or Insured Signature: _____ Date: _____

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History Form

PLEASE DO NOT LEAVE ANY ITEMS BLANK!

Patient Name:_____**Height:** _____ **Weight**:_____

What is your occupation? _____

Employment type: **Sits at job/ Stands at job / Stands & Walks / Sits & Stands / Retired / Unemployed**

Reason for your visit today (chief complaint):_____

Do you have diabetes? YES or NO **If yes**: TYPE 1 or TYPE II **Controlled by:** Insulin/Oral Medication/Diet

Do you have any artificial joints? YES or NO **If yes, please specify what joint(s)**:_____

Have you ever had or currently have an infectious disease (HIV, AIDS, ect.)? YES or NO
If yes, what type? _____

Current Medical Conditions or Past Illnesses: _____
_____
_____
_____

Past Surgeries: _____
_____
_____

Medications that you are taking: _____
_____
_____

Are you allergic to any medications? Please list: _____

Are you allergic to latex, adhesive, iodine, ect.? Please list: _____

List type of reaction you had: _____

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Family Medical History

Is your biological father LIVING or DECEASED? How did your father pass away? _____
_____

Is your biological mother LIVING or DECEASED? How did your mother pass away? _____
_____

Did/Does your biological father have: DIABETES / HEART DISEASE / CANCER / HYPERTENSION?

Did/Does your biological mother have: DIABETES / HEART DISEASE / CANCER / HYPERTENSION?

Did/Does your brother(s) or sister(s) have: DIABETES / HEART DISEASE / CANCER / HYPERTENSION?

Social History

Do you currently smoke? YES or NO If yes, how many per day? _____

If no, have you ever smoked in the past? YES or NO How many years has it been since you quit? _____

Do you drink alcohol? YES or NO

If yes, how much do you consume? (circle one): 1-2 PER DAY/ 2 OR MORE PER DAY / 1-2 PER WEEK / MONTHLY/ COUPLE TIMES A YEAR

Signature: _____ **Date:** _____

Oak Mill Medical Associates

I hereby authorize Oak Mill Medical Associates to render treatment and/or therapy to myself that is medically necessary in order to treat the conditions(s) I have requested.

Signature of Patient/Guardian: _____ **Date:** _____

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Missed Appointment and Cancellations:

Our office charges a $40/$70 fee for missed appointments and late cancellations.

We give a COURTESY appointment reminder call 48 hours in advance, but we are NOT responsible for remembering your appointment, YOU ARE! Therefore, if we have any technical difficulties we will still charge you as we just give COURTESY phone calls and you are ultimately responsible for your appointment.

For cancellations and reschedules, you must provide a 24-hour notice or you will be charged a missed appointment fee. This fee must be paid prior to your next visit.

If you arrive late to your appointment, we reserve the right to reschedule your appointment and charge a missed appointment fee.

Best contact number: _____ **Signature:** _____

Authorization of Payment (ALL Insurances)

I request that payment of Insurance benefits be made to OMMA for any services provided to me by that physician. I authorize any holder of medical information about me to release to the center for Medicare and Medicaid Services (CMS)/other insurance and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the carrier.

Signature:_____**Date:** _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party-payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
(Please look on clip board or in binder for copy of HIPAA)

On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories or physical therapy centers that you have been referred to, by OMMA, to aide in your coordination of care. We will not release your information to any third parties.

Designation of Certain Relatives, Close Friends, and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name:_____ Telephone: (_____)_____-_____ DOB: _____
Print Name: _____ Telephone: (_____)_____-_____ DOB: _____
Print Name: _____ Telephone: (_____)_____-_____ DOB: _____

The following person(s) are not authorized to receive my Patient Health Information (PHI):

Print Name: _____ **Print Name: _____**
Print Name: _____ **Print Name: _____**

_____ _____
Patient Name **Date**

_____
Relationship to patient (if not self)